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CENTER FOR ORTHOPAEDICS

1500 PLEASANT VALLEY WAY, SUITE 101
WEST ORANGE, NJ 07052

MEDICAL HISTORY FORM

Date: ____________________

Name: ____________________ Age: ______ Right Handed: ____ Left Handed: ____

Height: ________ Weight: ________

Reason for Visit: ____________________

List Present Medications: ____________________

____

Are you pregnant? __________

Have you ever had any of the following diseases or medical problems? Please answer each.

Y N Abnormal bleeding
Y N Alcohol/Drug Abuse
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV &+/ AIDS
Y N Hospitalized for any Reason
Y N Kidney Problems
Y N Liver Diseases
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)

Are you allergic to any of the following?

Y N Asprin
Y N Codine
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

List any other drugs that you are allergic to: ____________________

Do you smoke? Y N How much? ____________

Do you drink alcoholic beverages? Y N How much? ____________

Past Surgeries / Operations ____________________

Family History:

Osteoporosis Y N Kidney Stones Y N Cancer Y N
Diabetes Y N TB Y N High Blood Pressure Y N

Are you currently experiencing any of the following conditions?

Physician Review ____________
INITIALS

Please answer each question.

Constitutional Symptoms

Y N Fever
Y N Weight Loss
Y N Fatigue
Y N Night Sweats

Ear/Nose/Mouth /Throat

Y N Hearing Loss
Y N Dizziness
Y N Nose Bleeding
Y N Chronic Sinus Problems

Musculokeletal

Y N Joint Pains
Y N Back Pain
Y N Cold Extremities
Y N Joint Replacements

Gastrointestinal

Y N Loss of Appetite
Y N Change in Bowel Movements
Y N Frequent Diarrhea
Y N Constipation
Y N Blood in Stool
Y N Abdominal Pain/Heartburn
Y N Ulcer

Eyes

Y N Wear glasses/contacts
Y N Glaucoma
Y N Double Vision

Psychiatric

Y N Depression
Y N Insomnia
Y N Memory Loss

Respiratory

Y N Chronic Frequent Cough
Y N Asthma
Y N Shortness of Breath
Y N Spitting up Blood

Endocrine

Y N Diabetes
Y N Thyroid Disease
Y N Glandular or Hormone Problem
Y N Chronic Sinus Problems

Cardiovascular

Y N Heart Trouble
Y N Chest Pain or Angina
Y N Palpitations
Y N Shortness of Breath
Y N Swelling of Ankles or Hands
Y N Heart Murmur
Y N Mitral Valve Prolapse

Hematologic/Lymphatic

Y N Easy Bruising
Y N Anemia
Y N Phlebitis
Y N Enlarged Glands
Y N Past Transfusions

Neurological

Y N Numbness or Tingling
Y N Seizures
Y N Dizziness
Y N Stroke

Integumentary (Skin/Breast)

Y N Rash or Itching
Y N Change in Skin Color
Y N Varicose Veins
Y N Breast Lump
Y N Breast Discharge

I certify that the information that have provided is accurate ____________________
PATIENT SIGNATURE

Physician Review ____________________
INITIALS